Finance, Ways & Means Committee 1

Amendment No. 2 to HB0440

Sargent
Signature of Sponsor

AMEND Senate Bill No. 284* House Bill No. 440

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-1001, is amended by adding the following new subsection:

(f)

(1) A health insurance entity shall provide to any medical group practice with which the entity has an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete pursuant to this subsection (f).

(2)

(A) A health insurance entity shall notify a new provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application.

(B) If the application is incomplete and the new provider applicant submits additional information or documentation to complete the application, the health insurance entity shall comply with the requirements of subdivision (f)(2)(A) upon receipt of the additional information or documentation.

(C) A health insurance entity shall notify a new provider applicant of the results of the new provider applicant's credentialing application

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within ninety (90) calendar days after notification from the health insurance entity that the application is complete.

(D) If a new provider applicant fails to submit a complete credentialing application to a health insurance entity within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. If a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group and any other required documentation, to a health insurance entity within thirty (30) calendar days of notice of an incomplete application, then the new provider applicant is ineligible to receive the payment set out in (f)(3)(A).

(3)

(A) A new provider applicant shall not submit any claims for covered services provided by the new provider applicant to the health insurance entity for reimbursement while the credentialing application is pending. If claims are submitted while the credentialing application is pending, the health insurance entity may deny the claims. Upon notification pursuant to subdivision (f)(2)(C), the new provider applicant shall submit all held claims to the health insurance entity, and the health insurance entity shall pay reimbursement at the contracted in-network rate for any covered medical services provided by the new provider applicant during the time between receipt of a complete credentialing

application pursuant to subdivision (f)(2)(A) and notification pursuant to subdivision (f)(2)(C). In the event that a new provider applicant or medical group practice has specified a network start date for the new provider applicant that is later than the time of receipt of a complete credentialing application pursuant to subdivision (f)(2)(A), the health insurance entity shall pay reimbursement at the contracted in-network rate for any covered medical services provided by the new provider applicant during the time between the specified network start date and notification pursuant to subdivision (f)(2)(C).

(B) A health insurance entity's reimbursement obligation under subdivision (f)(3)(A) applies only to medical services provided in the name of the medical group practice by a new provider applicant that is billing for professional services under the existing group contract.

(4)

(A) Nothing in this section requires a health insurance entity to pay reimbursement at the contracted in-network rate for any covered medical services provided by the new provider applicant if the new provider applicant's credentialing application is not approved or the health insurance entity is otherwise not willing to contract with the new provider applicant.

(B) A medical group practice may be required to refund any reimbursement monies paid by the health insurance entity for services provided by a new provider applicant whose credentialing approval was obtained by fraud.

(C) A medical group practice shall not collect from a health insurance beneficiary any amount for services provided if the new

provider applicant's credentialing application is not approved or any amount refunded to a health insurance entity under subdivision (f)(4)(B).

(5) As used in this subsection (f):

(A) "Existing group contract" means a participating provider agreement between a medical group practice and a health insurance entity, under which physicians and other providers of the medical group bill for services provided to patients covered by health insurance provided by the health insurance entity, and under which a new provider applicant who is a member of the medical group practice will become a participating provider upon successful completion of the credentialing process;

(B) "Health insurance entity" has the same meaning provided in § 56-7-109(a); and

(C) "New provider applicant" means a physician or other licensed provider of medical services who has submitted a completed credentialing application to a health insurance entity.

(6) Nothing in this subsection (f) shall apply to the TennCare program or any successor Medicaid program provided for in title 71, chapter 5; the CoverKids Act of 2006, compiled in title 71, chapter 3, part 11; the Access Tennessee Act of 2006, compiled in title 56, chapter 7, part 29; any other plan managed by the health care finance and administration division of the department of finance and administration or any successor division or department; or the group insurance plans offered under title 8, chapter 27.

SECTION 2. This act shall take effect January 1, 2016, the public welfare requiring it, and shall apply to new provider applicant credentialing applications submitted to a health insurance entity on or after that date.